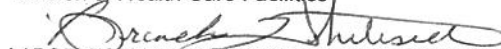


Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN0102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/12/2011
NAME OF PROVIDER OR SUPPLIER  SUMMIT VIEW OF LAKE CITY, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 204 INDUSTRIAL PARK RD LAKE CITY, TN 37769		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	<p>Initial Comments</p> <p>During a complaint investigation at Summit View of Lake City on July 12, 2011, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.</p> <p>C/O: #28293</p>	N 000			

Division of Health Care Facilities

  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrator

(X6) DATE

7/18/2011

STATE FORM

6899

S5M811

If continuation sheet 1 of 1

JUL 19 2011